STATE OF MICHIGAN
DEPARTMENT OF LABOR AND ECONOMIC DEVELOPMENT
OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

Kathryn Loomis Kilpatrick, DC	**04-394-BC**	**2004-101**
Kerry T. Kilpatrick, DC	**04-393-BC**	**2004-102**
Goss Chiropractic Clinics	**04-391-BC**	**2004-103**
Dustin Morton, DC	**04-388-BC**	**2004-104**
Christopher Passalacqua, DC	**04-392-BC**	**2004-109**
Corey B. Rodnick, DC	**04-398-BC**	**2004-112**
Richard N. Olree, Jr., DC	**04-397-BC**	**2004-177**
Kirby K. Perrault, DC	**03-361-BC**	**2003-914**

Petitioners

v **CONSOLIDATED**

Blue Cross and Blue Shield of Michigan,

Respondent

_____/

For the Petitioner:

Alan T. Rogalski (P44550)
Foster, Swift, Collins & Smith, P.C.
32300 Northwestern Highway
Suite 230
Farmington Hills, MI 48334
(248) 538-6354
FAX (248) 851-7504
arogalski@fosterswift.com

For the Respondent:

Robert A. Phillips (P58496)
BCBSM, Litigation Section
Mail Code #1925
600 Lafayette East
Detroit, MI 48226-2998
(313) 225-0536
FAX (313) 225-6702
rphillips@bcbsm.com

_____

Issued and entered
this 29th day of December 2005
by Linda A. Watters
Commissioner

FINAL DECISION

I
BACKGROUND

The eight chiropractors ("Chiropractors") involved in this matter performed services for subscribers of Blue Cross and Blue Shield of Michigan ("BCBSM") in 1999 and 2000. BCBSM paid for the services. In subsequent audits, BCBSM determined that it had overpaid the Chiropractors for office visits and mechanical tractions. These types of services were covered, but the number of services per subscriber exceeded limits in their certificates. BCBSM sought refunds from the Chiropractors ranging from $2,000 to $118,000, which totaled $248,000.

Following informal reviews, the Chiropractors sought and obtained this contested case. The parties stipulated to key facts, submitted affidavits, and filed briefs. On November 12, 2004, the Administrative Law Judge issued a Proposal for Decision. He recommended that the Commissioner find no violation by BCBSM of claims payment standards and that the Commissioner deny the Chiropractors' request for a ruling that BCBSM is not entitled to refunds. The Chiropractors filed Exceptions.

Except as noted below, the factual findings in the Proposal for Decision are in accordance with the preponderance of the evidence and the conclusions of law are supported by reasoned opinion. The Proposal for Decision is attached, adopted, and made part of this Final Decision except insofar as it is inconsistent with findings and conclusions below. While no claims handling violations are found, the recommendation of the Administrative Law Judge as to refunds is not accepted. The mistaken payments were the fault of BCBSM and the Chiropractors reasonably relied upon those payments to their detriment.

II
ANALYSIS

The Chiropractors' Exceptions fall into three categories. First, they dispute the rejection by the Administrative Law Judge of some of their proposed findings of fact. Second, they object to certain conclusions he reached regarding claims handling standards. Third, they assert that he wrongly applied case law governing the mistaken payment of insurance claims.

Proposed Findings of Fact

The Chiropractors disagree with the Administrative Law Judge's rejection of several of their proposed findings of fact. That rejection should not be disturbed for the following reasons: the exceptions did not adhere to R 500.2131 of the Hearing Procedures Rules, which provides, "Written argument in support of an exception shall specify the facts and law upon which the party relies…"; several of the proposed findings would not, as required by MCL 24.285, "... control the decision..."; several of the proposed findings include, as noted by the Administrative Law Judge, legal argument; and, given the additional findings of fact below in favor of the Chiropractors, it would serve no purpose.

Claims Handling Standards

In their Exceptions, the Chiropractors argue that the Administrative Law Judge wrongly found BCBSM complied with claims handling requirements set forth in MCL 550.402(1). These exceptions do not warrant departing from the Proposal for Decision. First, overall, the section-by-section analysis by the Administrative Law Judge is well reasoned. Second, while MCL 550.1402(1) may apply to post-claim audits and refunds, it was not designed to cover the mistaken payment of claims. For example, the prohibition on misrepresentation is intended to prevent the wrongful denial of claims, not the mistaken payment of claims. Third, the remedy for the

mistaken payment of claims is grounded in MCL 550.1403(1). This section, in conjunction with case law governing the mistaken payment of insurance claims, provides a basis for the Commissioner to determine that BCBSM is not entitled to the refunds it seeks in this matter.

Mistaken Payments and Detrimental Reliance

The law governing the recovery of mistaken payments reaches back to 1887 in Michigan. In *Walker v Conant*, 65 Mich 194, 197, 198 (1887), the Michigan Supreme Court held:

> The rule is general that money paid under a mistake of material facts may be recovered back, although there was negligence on the part of the person making the payment; but this rule is subject to the qualification that the payment cannot be recalled when the situation of the party receiving the money has been changed in consequence of the payment, and it would be inequitable to allow a recovery.

This holding was recently confirmed by the Michigan Supreme Court in Wilson *v Newman*, 463 Mich 435 (2000). The Supreme Court stated [at 435]:

> We adhere to prior Michigan law, which permits recovery of mistaken payments absent detrimental reliance by the payee.

In remanding the case for further proceeding, the Court stated [at 443]:

> The plaintiff's have contended that they in fact were prejudiced by the defendant's mistaken payment, for example, forgoing other collection efforts that may not now be available. If the plaintiffs can demonstrate a change in position or a detrimental reliance as a consequence of having received the mistaken payment, they may be entitled to retain all or part of the funds mistakenly paid by Allmerica…

The Court also addressed how this applies to medical providers--such as the Chiropractors in this contested case--who first confirm coverage with a health carrier before providing services. In Footnote 4, it observed [at 442]:

> Indeed, even under the established Michigan law, denial of reimbursement in *Shield Benefit* may well have been appropriate. In that case, before providing service to the patient, the defendant medical center obtained preauthorization from the Shield Benefit agent. Thus, the medical center was arguably relying on the expected payments from Shield Benefit in rendering services to the insured.

The Administrative Law Judge was aware of the *Walker* standard, but applied it incorrectly. He properly found that BCBSM failed to disclose benefit limitations in its hotlines, which answer medical provider questions about the coverage on prospective or current patients. He correctly found that BCBSM failed to perform "edits" on submitted claims that would have caused a rejection of claims based upon the limitations. In short, BCBSM paid claims mistakenly because its claim review system was not made current when the office visit and mechanical traction benefits were added.

The Administrative Law Judge also appropriately found that the overpayments--in light of the refunds sought--were detrimental to the Chiropractors. In particular, secondary insurers, such as automobile insurers paying personal injury protection benefits, typically have one-year limitations on claims. Since the overpayments were only identified more than a year after they were made, the Chiropractors could not look to the secondary insurers for payment of their services. Even if they could legally pursue their patients for these old services rendered, their likelihood of success was greatly diminished.

Given the mistaken payments and the detriment to the Chiropractors, the outcome, in light of *Wilson,* might seem automatic: BCBSM is not entitled to the refunds. However, the Administrative Law Judge, in effect, considered the reliance of the Chiropractors on the mistaken payments to be unreasonable.

In reaching his result, the Administrative Law Judge gave too much weight to the fact that the Chiropractors were aware of general limitations as to office visits and mechanical tractions. He did not give appropriate weight to the control BCBSM exercises as to the implementation of these and other limitations. When that is taken into account, it is clear that the Chiropractors were

reasonable in relying on the overpayments they received from BCBSM. This warrants additional findings of fact and conclusions of law.

III
ADDITIONAL FINDINGS OF FACT

Based upon the record in this matter, the Commissioner makes the following findings of fact in addition to those contained in the Proposal for Decision. To the extent any of the findings of fact in the Proposal for Decision are inconsistent with the findings below, they are superseded. The Commissioner finds that:

1. BCBSM is the architect, builder, and manager of its health benefit plans. It composes certificates, files those certificates for approval, informs health care providers regarding benefits, keeps track of which certificates apply to particular subscribers, provides an inquiry system so providers can ascertain eligibility and benefit levels of individual patients, screens claims to determine which services are covered, and informs providers of claim denials.
2. In determining whether to provide services for a particular patient, and in determining the scope of those services, the Chiropractors looked to the inquiry systems established by BCBSM to ascertain eligibility and benefit levels of patients.
3. BCBSM had a duty to update the inquiry systems so that they would supply correct information respecting the services to be covered beginning March 1999. It did not do so in 1999 or 2000.

4. In making calls to these inquiry systems, the Chiropractors were not informed of limitations as to office visits or mechanical tractions. They performed services relying upon the information they received.
5. Even where a health care provider thinks a service may not be covered, the provider will submit a claim to BCBSM where a secondary insurer may cover the service. Secondary insurers require denials from primary insurers before covering claims. BCBSM does this itself where it is a secondary insurer.
6. BCBSM was aware that secondary insurers typically have claims filing limitation periods of a year or less. It had a 180-day limitation period.
7. BCBSM knew that, if it mistakenly paid a claim, the Chiropractors and their patients would lose the opportunity to make a claim on a secondary insurer if the error was not detected within one year. It also knew that the Chiropractors could not look to the secondary insurers for payment of the services they rendered.
8. When the new coverages were added in March 1999, BCBSM had a duty to add "edits" to its claim screening process so that services provided beyond the limitations would be denied. It did not do so in 1999 or 2000.
9. Even where a health care provider thinks a service may not be covered, the provider may submit a claim to BCBSM because different plans have different limitations and plans may be modified during the year.
10. The Chiropractors were not in a position to determine the specific coverage of a specific patient. Only BCBSM has the records necessary to make such determinations.

11. BCBSM is aware that medical care providers depend upon its claims review system for determinations of coverage.
12. In communications to chiropractors respecting the new coverages, there was no mention that edits would not be put in place with respect to limitations. The Chiropractors had no notice that they would need to establish special claim submission or review standards as to the new coverages and limitations on those coverages.
13. The Chiropractors reasonably relied on the BCBSM coverage inquiry hotlines and the BCBSM claims screening process in the submission of claims and the receipt of payments.
14. In summary, the Chiropractors received some claim payments due to the mistake of BCBSM. They reasonable relied upon BCBSM systems in the provision of services, the submission of claims, and the receipt of payments. They relied to their detriment in receiving these payments because, due to the passage of time, they legally lost the opportunity to receive payments from secondary insurers and they practically, if not legally, lost the opportunity to receive payments from their patients.

IV
ADDITIONAL CONCLUSIONS OF LAW

Based upon the statutory law and case law applicable to this matter, the Commissioner makes the following conclusions of law in addition to those contained in the Proposal for Decision. To the extent any of the conclusions of law in the Proposal for Decision are inconsistent with the conclusions below, they are superseded. The Commissioner concludes:

1. MCL 550.1403(1) established the general obligation of BCBSM to make claims payments to the Chiropractors.
2. Provisions in the Physician and Professional Provider Participation Agreement [Addendum G] respecting overpayments did not specifically address overpayments that are the mistake of BCBSM. "Audit refunds recovery situations" indicates the focus was upon errors by providers detected by BCBSM in an audit. Moreover, BCBSM had obligations under the Provider Agreement to establish and maintain reliable benefit inquiry systems and claims processing systems [Page 1, paragraphs 3 and 4], which it failed to meet with respect to the Chiropractors.
3. Under *Wilson*, a party may not recover mistaken payments when there has been detrimental reliance by the payee.
4. BCBSM is not entitled to the refunds sought in this matter.

Additional Matters

The Chiropractors requested oral argument before the issuance of the Final Decision. However, the record and previous arguments of the parties were sufficient, so the Commissioner proceeded directly to this decision.

Finally, in connection with the refunds, BCBSM withheld $28,240.30 from Dr. Corey B. Rodnick for other services he provided. BCBSM should be ordered to pay him this amount, plus interest as provided in MCL 550.1403(1).

V
ORDER

Therefore, it is ORDERED that:

1. BCBSM is not entitled to the refunds it sought in this matter.

2. BCBSM shall pay $28,240.30 to Dr. Rodnick, plus interest as provided in MCL 550.1403(1).